No. 89-1044

IN THE
Supreme Court of the United States
OCTOBER TERM, 1989

OCEAN STATE PHYSICIANS
HEALTH PLAN, INC., ET AL.,

Petitioners,

v.

BLUE CROSS AND BLUE SHIELD OF RHODE ISLAND,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS FOR THE
FIRST CIRCUIT

BRIEF OF U.S. HEALTHCARE, INC. AS AMICUS CURIAE IN SUPPORT OF THE PETITIONERS

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INTEREST OF AMICUS CURIAE

Pursuant to Rule 37 of the Rules of this Court, U.S. Healthcare, Inc. ("U.S. Healthcare") files this brief as *amicus curiae* in support of the petition for writ of certiorari.[1]

U.S. Healthcare, through subsidiaries, owns and operates health maintenance organizations ("HMOs") in certain northeastern states. In its markets, U.S. Healthcare's HMOs primarily compete with long-entrenched Blue Cross and Blue Shield indemnity insurance plans.

The decision of the Court of Appeals constitutes not only a marked departure from existing antitrust law, it

1. Letters of consent from both parties have been lodged with the Clerk of the Court.

validates a plan for monopolization in an important segment of the health care industry. If the decision of the Court of Appeals is permitted to stand, the exclusionary pattern adopted by Blue Cross and Blue Shield of Rhode Island may be replicated by the dominant plans in other markets, enabling them to maintain their supremacy by stifling beneficial competition. In particular, U.S. Healthcare could easily become the next intended victim of the same type of blatant anti-competitive scheme that victimized Ocean State here. More importantly, the Court of Appeals' decision permits entrenchment of outmoded health care monopolists, a result that will ultimately increase the already rampant inflation in health care costs by discouraging competition and innovation. Left unchecked, this static monopolization will exacerbate the nation's health care crisis and result in the denial of care to those who cannot afford higher costs.

The HMOs operated by U.S. Healthcare generally are qualified under the provisions of the Health Maintenance Organizations Act of 1973, 42 U.S.C. § 300e *et seq.* ("HMO Act"). The HMO Act articulates Congress' intent to foster the growth of HMOs as an alternative to the traditional form of health care indemnity insurance epitomized by Blue Cross and Blue Shield.

The benefits available to the members of U.S. Healthcare's HMOs are significantly different from those provided by traditional health insurance, which covers medical care on a fee-for-service basis. Physicians submit bills and are paid a portion of the cost of the services by the insurer. In addition to monthly premiums, members are required to contribute a substantial deductible that may average approximately twenty percent (20%) for some services and higher for others. Some services, such as routine preventive check-ups, are often not covered at all. The principal attraction of the traditional plans is that they offer unlimited physician choice in the form of partial reimbursement to the member for the costs of certain physician services.

In contrast, U.S. Healthcare's HMOs provide comprehensive benefits, including: (1) physician services (including consulting and referral services); (2) inpatient and outpatient hospital services; (3) medically necessary emergency health services; (4) short-term mental health services; and (5) medical treatment and referral services for the abuse of or addiction to alcohol and drugs. 42 U.S.C. § 300e-1(1). Physician care services are provided to members by independent private physicians who contract with U.S. Healthcare. 42 U.S.C. § 300e(b)(3). The care is provided in the offices of the participating primary and specialist physicians, not in a facility established by the HMO.[2]

Under the U.S. Healthcare model, participating primary care physicians are not paid on a fee-for-service basis. Rather, they are paid according to a method known as "capitation." The capitation system pays the physician an amount at periodic intervals for each member who has selected that physician regardless of whether the particular patient seeks any health care during the period. The frequency and size of capitation payments depend on various factors, including the quality of care. The fundamental principle underlying this method of compensation is to provide physicians with a financial incentive to keep their patients healthy.

Physician services are covered in full by the HMO except for nominal copayments for primary care physician visits. Medically necessary visits to specialists and hospital stays are covered in full when authorized by the primary care physician, while medically necessary emergency treatment is reimbursable less a modest copayment. Many members also opt for prescription coverage which pays for most

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2. Amicus Kaiser Permanente, by contrast, provides health care to its members by physicians who practice solely for the HMO at facilities owned and operated by Kaiser. *See* Brief of Kaiser Foundation Health Plan, Inc. as Amicus Curiae in Support of Petitioners at 2.

prescription drugs less a small copayment. This model lowers the financial barrier to quality, comprehensive and coordinated care.

The public interest, as articulated in the federal HMO Act and various state statutes, demanded more cost-effective and comprehensive health care coverage. The HMO Act implicitly recognized that the traditional indemnity plans were not adequately meeting the needs of society. The stark contrast between HMOs and traditional indemnity plans can best be understood by comparing the physician compensation methods. U.S. Healthcare's HMOs pay their participating physicians in a manner that encourages them to foster patient health. However, by compensating on a fee-for-service basis, the traditional indemnity plans give physicians a financial incentive to provide more care than is necessary. The lack of any coordination of care also creates waste and inefficiency.

U.S. Healthcare's HMOs provide more benefits for each premium dollar. Health and wellness are fostered through care that is more comprehensive than that covered by traditional indemnity plans. HMOs are often an attractive choice for younger subscribers, who ordinarily have not yet developed particular physician relationships, because it is both more affordable and comprehensive. *See Ocean State Physicians Health Plan, Inc.*, 692 F. Supp. 52, 59 (D.R.I. 1988) (discussing Blue Cross & Blue Shield's fear that younger subscribers would "adversely select" Blue Cross in favor of an HMO). Furthermore, where HMOs compete successfully, they attract sufficient numbers of physicians to offer a choice that compares favorably with that of the traditional plans. The dramatic growth of HMO enrollments in markets where they are not subject to unfair predation demonstrates clearly that HMOs meet the public's need for affordable, comprehensive, quality health care. Indeed, U.S. Healthcare's HMOs presently have approximately 1,070,000 members, up from 794,000 at the end of 1987.

Like Ocean State, U.S. Healthcare is extremely vulnerable to predatory and exclusionary conduct by the dominant plans. Blue Cross type plans generally offer unlimited physician choice, while HMOs, especially in their start-up stage, cannot offer the same breadth of choice. More importantly, the Blue Cross type plans have been the dominant health care insurers in most areas for over fifty years. The Blue Cross plans have the power to influence employers' decisions since employers are reluctant not to offer their employees at least one unlimited physician health care plan. Physicians are also susceptible to coercion since they are unlikely to flout the number one "purchaser" in the market. Blue Cross type plans are capable of excluding competitors by exerting pressure at both the financing and purchasing ends of the health care spectrum. HMOs operated by Blue Cross plans have many of these same economic tools at their disposal.

The issue of health care costs is an increasingly pressing issue for this nation, particularly as the population grows statistically older. Health care expenditures now amount to almost twelve percent (12%) of the gross national product, making the health care field one of the most significant in the American economy.[3] As the HMO Act implicitly recognized, one effective way to combat soaring health care costs is to nurture competition in the industry. Competition engenders efficiency and cost-effectiveness while maintaining a high level of quality. Such nurturing cannot take place where the dominant force in the market has the power literally to nip the competition in the bud by effectively denying it the ability to build a physician

3. In 1987, total health spending was $500.3 billion or 11.1 percent of the gross national product. It is estimated that health care spending will increase to 12.0 percent of GNP in 1990. This contrasts with healthcare's 5.9 percent share of GNP only twenty-five years ago. Altman, *Changes in Medicine Bring Pain to Healing Profession*, N.Y. Times, February 18, 1990, at A1, col. 4 (hereafter "Altman").

network and to construct upon that platform an economically viable enrollment. Absent a physician network, no HMO can compete for employers or members.

As with Ocean State, the ability of U.S. Healthcare to compete in new markets depends upon physician participation. The decision of the Court of Appeals blocks competitors' access to eligible physicians and insulates from antitrust liability precisely the type of exclusionary conduct that the Sherman Act was designed to prevent. The Court below permitted the monopolist to maintain monopoly power at a time where the needs of society demand progressive changes in the health care system fueled by fair competition. Moreover, the effect of this conduct flies in the face of federal policy to foster the growth of HMOs as expressed in the HMO Act. Accordingly, U.S. Healthcare submits this brief as *amicus curiae* in support of the petition for certiorari to underscore the significance that this case holds both for the health care industry and health care consumers.

REASONS FOR GRANTING THE WRIT

I. INTRODUCTION

This case presents one central issue for this Court's consideration. The nation is faced with a crisis in the cost and quality of health care.[4] Yet the decision of the Court of Appeals sanctions a veritable blueprint for monopolization. The decision permits those plans that have dominated the markets for health care since the Great Depression to maintain their stranglehold by engaging in intentionally exclusionary conduct designed to stifle incipient competi-

4. Dr. Louis W. Sullivan, Secretary of Health and Human Services, recently remarked on the health care crisis, noting that: "[w]e've known for 15 years that we've had rising costs and that if things were not done to bring them under control there would come a day when there would be a reaction . . . We've reached that point." Altman at A35, col. 1.

tion from necessary alternatives, such as HMOs. Specifically, the petition for certiorari asks whether public policy and long-standing Sherman Act jurisprudence can countenance monopolistic behavior that can only have adverse effects on American health care.[5] The issues presented in the petition are of vital importance to the public and are deserving of resolution.

II. THE DECISION OF THE COURT OF APPEALS PORTENDS SERIOUS CONSEQUENCES FOR THE NATION'S HEALTH CARE AND CONSTITUTES A RADICAL DEPARTURE FROM LONG-STANDING SHERMAN ACT JURISPRUDENCE

Both the District Court and Court of Appeals recognized that Blue Cross and Blue Shield of Rhode Island ("Blue Cross") held monopoly power with a market share in excess of eighty percent (80%). *See Ocean State Physicians Health Plan, Inc. v. Blue Cross and Blue Shield of Rhode Island*, 883 F.2d 1101, 1110 (1st Cir. 1989). Blue Cross had contracts with more than ninety percent (90%) of the physicians in Rhode Island. Blue Cross controlled the market from both ends, both as a "supplier" of physician services to employers who purchased health benefits coverage and as a "purchaser" of physician services for the patient population.

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5. In recognition of the pressing issues facing the health care industry, the Justice Department has singled out the industry for particular scrutiny under the antitrust laws. *See* L.A. Times, February 3, 1990 at A2, col. 1. The health care industry was to be targeted because the industry is one of the "most important segments of our economy. . . ." and there are indications that anti-competitive practices are taking place that run up costs significantly. Proprietary to the United Press International, *Administration Plans New Antitrust Effort*, December 14, 1989.

Notwithstanding Blue Cross' dominance, Ocean State enjoyed remarkable success in the few short years after it entered the Rhode Island market. Ocean State gathered a ten percent (10%) market share in two years along with a strong level of physician support. As a result of its innovations, Ocean State was able to offer consumers a benefit package that was fifteen percent (15%) broader than the Blue Cross package, at a price that was five percent (5%) to seven percent (7%) lower.

To counteract the damage to its business and stop the inroads that Ocean State was making into the Rhode Island market, Blue Cross developed a three-pronged plan of attack. This brief addresses only the third prong known as the "Prudent Buyer" policy. Pursuant to this policy, Blue Cross announced that it would pay no more for a physician's services than the physician was accepting from any competitor of Blue Cross. U.S. Healthcare supports the petitioner's belief, and the opinion of the properly instructed jury below, that this program was a deliberate, exclusionary effort to reduce competition in the Rhode Island health care market.

A. The Court of Appeals Deviated from Consistent Sherman Act Precedent and Sanctioned Monopolization

Where a decision of a Court of Appeals is in conflict with applicable decisions of this Court, review upon a writ of certiorari is appropriate. *See Braen v. Pfeifer Oil Transportation Co.*, 361 U.S. 129, 130 (1959). In the present case, the decision of the Court of Appeals sanctions "undue, unfair, or anti-competitive exclusion of rivals" by the dominant competitor in the Rhode Island health care field. *See* Krattenmaker and Salop, *Anticompetitive Exclusion: Raising Rivals' Costs to Achieve Power Over Price*, 96 Yale L.J. 209, 219 (1986) (synthesizing policy underlying this Court's leading antitrust decisions). Such a result directly

conflicts with the opinions of this Court which have consistently refused to condone exclusionary monopoly behavior.[6]

The conduct of Blue Cross in Rhode Island exhibits both of the necessary elements of the offense of monopoly under Section Two[7] of the Sherman Act: (1) possession of monopoly power in the relevant market; and (2) willful acquisition or maintenance of that power as distinguished from growth or development as a consequence of a superior product, business acumen, or historic accident. *United States v. Grinnell Corp.*, 384 U.S. 563, 570-71 (1966). The Court of Appeals decision transforms the monopolist's ability to willy-nilly quash smaller competition into "business acumen." This is contrary to the intent underlying the antitrust laws.

On the basis of this two-step test, this Court consistently has condemned monopolistic conduct having the effect of excluding competitors from markets. *See, e.g., Aspen Skiing Co. v. Aspen Highlands Skiing Corp.*, 472 U.S. 585 (1985); *Lorain Journal Co. v. United States*, 342 U.S. 144 (1951); *Standard Oil Co. of Cal. v. United States*, 337 U.S. 293 (1949); *United States v. United Shoe Mach. Co.*, 110 F. Supp. 295 (D. Mass. 1953), *aff'd per curiam*, 347 U.S. 521 (1954). Yet, despite this clear antipathy toward willful exclusion of competitors by unlawful means, the Court of Appeals validated a monopolistic business program.

The court below based its conclusion on two factors. First, the court found that the Prudent Buyer policy was an effort by a purchaser to achieve a low but not predatory price from its suppliers, an arrangement that "appear[ed]

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6. The fundamental policy underlying the Sherman Act is to preserve competition as the national economic goal. *United States v. Philadelphia National Bank*, 374 U.S. 321, 372 (1963); *Northern Pacific Ry. Co. v. United States*, 356 U.S. 1, 4 (1958); *Apex Hosiery Co. v. Leader*, 310 U.S. 469, 495, n. 16 and cases cited therein (1940).

7. 15 U.S.C. § 2.

to bring low price benefits to the consumer." 883 F.2d at 1111. This was deemed to be a competitive course of conduct justified by valid business reasons and economic efficiency. *Id.* at 1112. Second, the court noted its reluctance to interfere in the domain of medical costs, "an area of great complexity where more than solely economic values are at stake." *Id.*, quoting *Kartell v. Blue Shield of Massachusetts*, 749 F.2d 922, 931 (1st Cir. 1984), *cert. denied*, 471 U.S. 1029 (1985). Then, as if by circular reasoning, the court determined that since Blue Cross' conduct was itself legitimate, the fact that the evidence indicated that the Prudent Buyer policy was *intended* to destroy or weaken Ocean State was "irrelevant." 883 F.2d at 1113.

The Court of Appeals' reasoning turns the method traditionally used to infer the intent element of monopolization on its head. Intent to monopolize is inferred from illegal acts, unfair business practices or conscious attempts to strengthen and maintain existing monopoly power. *United States v. Griffith*, 334 U.S. 100, 107-08 (1948); *United States v. United Shoe Mach. Corp.*, *supra*. at 342. It strains common sense to reason, as the Court of Appeals did, that a clearly expressed intent can be rebutted by "legitimate" conduct, particularly where that conduct maintains monopoly power. Indeed, explicit intent plus market dominance establishes the complete offense of monopoly. *See United States v. Grinnell Corp.*, *supra*. at 570-71.

The Court below expressly found that (1) Blue Cross was the *monopolist* in the Rhode Island market, and (2) the Prudent Buyer program was *willful*. 883 F.2d at 1110, 1113. Nonetheless, the Court of Appeals willingly sanctioned Blue Cross' actions as somehow distinguishable from otherwise illegal maintenance of its monopoly power. The court's particular predisposition to maintain this hands-off approach to the health care industry is all the more disturbing in light of the current health care crisis and the

articulated public policy favoring the growth of HMOs. Prudent Buyer was not the consequence of superior business acumen or healthy competition. Rather, it was a deliberate attempt at monopoly maintenance.[9] Indeed, if Ocean State's rapid success is any indication, it, rather than Blue Cross, possessed the superior products and business acumen.

B. The Public Interest Will Be Harmed If The Court of Appeals' Decision is Left Undisturbed

Congress clearly expressed its intent that HMOs be made widely available as a health care alternative almost twenty years ago.[10] In aid of this goal, Congress resolved that local exclusionary practices seeking to bar HMOs were *unlawful*. Section 300e-10(a) of the HMO Act provides that restrictive state laws and practices prohibiting entities

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9. Judge Wyzanski's characterization of the leasing practices involved in *United States v. United Shoe Mach. Corp.*, *supra*, is equally applicable to the Prudent Buyer program:

> [T]hey are not practices which can be properly described as the inevitable consequences of ability, natural forces, or law. They represent something more than the use of accessible resources, the process of invention and innovation, and the employment of those techniques of employment, financing, production, and distribution, which a competitive society must foster. They are contracts, arrangements, and policies which, instead of encouraging competition based on pure merit, further the dominance of a particular firm. In this sense, they are unnatural barriers; they unnecessarily exclude actual and potential competition; they restrict a free market.

Id. at 344-45.

10. § 300e-9 of the HMO Act, 42 U.S.C. § 300e-9(a), provides that employers must offer an HMO as one health benefits option to their employees.

from operating as HMOs shall not apply.[11] Thus, even without considering the proscription against abuse of monopoly power contained in the Sherman Act, there is a federal mandate for the establishment, protection and nurturing of HMOs.

Despite this clear policy, the Court of Appeals approved Blue Cross' conduct. When the court focused narrowly on the terms of the Prudent Buyer program and, at the same time, ignored its actual and *intended* effect, the court missed the true import of the Prudent Buyer Program, which was to make it as difficult as possible for an independent HMO to take root in Rhode Island. While the form of the program — seeking lower prices from physicians — arguably benefitted consumers in the short term, the long range consequences of Blue Cross' success will be

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11. Section 300e-10(a), provides, in pertinent part:

In the case of any entity —

(1) which cannot do business as a health maintenance organization in a State to which it proposes to furnish basic and supplemental health services because that State by law, regulation, or otherwise —

(A) requires as a condition to doing business in that State that a medical society approve the furnishing of services by the entity,

(B) requires that physicians constitute all or a percentage of its governing body,

(C) requires that all physicians or a percentage of physicians in the locale participate or be permitted to participate in the provision of services for the entity,

[or]

(D) requires that the entity meet requirements for insurers of health care services doing business in that State respecting initial capitalization and establishment of financial reserves against insolvency. . . .

[s]uch requirements shall not apply to that entity so as to prevent it from operating as a health maintenance organization. . . .

to entrench its market monopoly by raising rivals' costs of competition. *See* Krattenmaker and Salop, *Anticompetitive Exclusion: Raising Rivals' Costs to Achieve Power Over Price*, 96 Yale L.J. 209 (1986). Yet, since the HMO traditionally offers more comprehensive coverage at lower rates, its financial success depends on the ability to pay physicians less than they are paid by Blue plans (whose premiums and copayment ratios are higher).

Once competition is stifled, premiums will again rise, health care coverage will become more difficult for many to afford and health care quality will suffer.[12] Exclusionary practices in other geographical markets will follow, with similar effects. More importantly, the alternatives offered by new, innovative entrants in the health care industry will be threatened as competition becomes more costly and the prospects of success appear less promising. This is of particular concern to U.S. Healthcare since, although the company enjoys a substantial market share in Pennsylvania and New Jersey, it is a relative newcomer to states such as Connecticut, Massachusetts and New Hampshire. U.S. Healthcare remains vulnerable to unfair monopolistic practices in these states and the states to which it may expand in the future.

This is not an illusory concern. U.S. Healthcare recently has become the target of one scheme that is blatantly unlawful, though the monopolist's conduct might be viewed as permissible should the Court of Appeals' decision stand. In New Hampshire, a competitor is attempting to

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12. Monopoly power means that a monopolist may be freed from pressure to reduce costs, to develop new products, or to raise the quality of goods and services sold. 2 E.W. Kintner, *Federal Antitrust Law*, § 11.3 at 307 (1980) (hereafter "Kintner"). Judicial decisions involving Section Two of the Sherman Act have condemned in particular a monopolist's power to raise prices, restrict output, and lower the quality of goods and services. *See, e.g., United States v. Standard Oil Co.*, 221 U.S. 1 (1911); Kintner, *supra* at 307.

cement its grip on the market against incipient competition by adopting a program intended to prevent U.S. Healthcare from gaining a foothold in the market. Specifically, the competitor has "approved a substantial capitation rate increase to those primary care physicians *who will maintain exclusivity* with us. . . ." In other words, the competitor, perhaps encouraged by the decision below, has implemented the plainly exclusionary policy of paying physicians more to stay away from competing plans. The net effect of the program will be to prevent incipient competition in the New Hampshire market with the resultant negative effects of a monopolistic or oligopolistic marketplace. The ultimate losers will be the employers who will pay higher premiums than necessary and the consumers who will not receive the choice and quality of care which fair competition would allow.

If this sort of practice can occur in one locale, it is likely to be successful in other places. Certainly, public policy and sound precedent underlying the antitrust laws should not condone this practice.

CONCLUSION

The decision of the Court of Appeals deviates from long-standing Sherman Act jurisprudence and ignores the Congressional intent underlying the HMO Act of 1973. In so doing, it insulates health care insurers from antitrust liability. There is no sound basis for treating the health care industry differently, particularly when monopolization is an important factor contributing to the nation's health care crisis. Accordingly, the writ of certiorari should issue to review the judgment of the United States Court of Appeals for the First Circuit.

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